STATE OF MICHIGAN

IN THE SUPREME COURT

BRONSON METHODIST HOSPITAL,

Plaintiff/Appellee,

v.

MICHIGAN ASSIGNED CLAIMS FACILITY,

Defendant/Appellant.

Supreme Court Case No. 151343-4

COA Docket Nos. 317864 & 317866
(Consolidated)

Lower Court Case No. 12-0600-NF
Kalamazoo County Circuit Court
Hon. Gary C. Giguere, Jr.

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BRONSON METHODIST HOSPITAL'S SUPPLEMEMTAL BRIEF IN OPPOSITION TO MICHIGAN ASSIGNED CLAIMS PLAN'S APPLICATION FOR LEAVE TO APPEAL

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STATEMENT OF QUESTION PRESENTED FOR REVIEW

I. WHETHER THE COURT OF APPEALS ERRED WHEN IT CONCLUDED THAT THE DEFENDANT MICHIGAN ASSIGNED CLAIMS PLAN COULD NOT DENY THE PLAINTIFF HOSPITAL'S APPLICATION FOR ASSIGNMENT OF ITS CLAIM FOR BENEFITS AS "AN OBVIOUSLY INELIGIBLE CLAIM," MCL 500.3173a.

Plaintiff's Answer: No.

Defendant's Answer: Yes.

INTRODUCTION

MCL 500.3173a(1) provides that the MACP may only deny "obviously ineligible" claims. In making that determination, the MACP must restrict its review to submitted application documents. Allowing the MACP to step outside of those documents and deny claims based on unknown information is inconsistent with the restrictive language of MCL 500.3173a and MCL 500.3172, which specifically provides that a claim may be made to the MACP where "no personal protection insurance applicable to the injury can be identified." Accordingly, the Court of Appeals correctly decided that the MACP could not deny Bronson's claim for benefits as "an obviously ineligible claim."

STATEMENT OF FACTS[1]

I. CIRCUMSTANCES GIVING RISE TO LITIGATION.

At 3:10 a.m. on July 6, 2012, Cody Esquivel was injured in a motor vehicle accident. He was transported via Air Care to Bronson's emergency room, where he was intubated and admitted as Level 1 Trauma. Bronson's treatment to Esquivel included CT scans of his head and body, x-rays, lab work, and treatment for a broken finger, for which Bronson's charges totaled $21,914.22.

Given the circumstances of his arrival at the hospital, Bronson did not receive any information from Esquivel regarding no-fault insurance. Esquivel was discharged approximately 12 hours later before Bronson's registration personnel had the opportunity to interview him. Bronson took various steps to contact Esquivel post-discharge and identify no-fault coverage but was unable to do so.

[1] In light of this Court's order that the parties not submit restatements of their application papers, Bronson omits a full statement of facts. It relies on the facts set forth in its application papers but provides a truncated statement of facts for ease of review.

On October 24, 2012, having been unable to reach Esquivel, Bronson submitted an application for benefits to the MACP along with supporting documentation, noting that Esquivel's insurance status was "unknown." A week later, the MACP denied Bronson's application on the grounds that "[t]he owner or co-owner of an uninsured motor vehicle or motorcycle involved in an accident is not eligible for benefits."

II. PROCEDURAL HISTORY.

On November 16, 2012, Bronson filed its Complaint, seeking declaratory judgment and a writ of mandamus directing the MACP to assign Bronson's claim to a no-fault carrier. Before any discovery had been conducted, the MACP moved for summary disposition, taking the position that Bronson's claim was "obviously ineligible" pursuant to MCL 500.3173a(1) because Esquivel was either (1) uninsured, in which case he should be excluded from receiving no-fault benefits as an uninsured owner, MCL 500.3113(b) or (2) insured, in which case his own insurance carrier, not an MACP-assigned carrier, was responsible for paying the bill.

The circuit court granted summary disposition to the MACP. Following a dispute over attorney fees, Bronson appealed. On February 19, 2015, the Court of Appeals reversed the circuit court in an unpublished opinion. It concluded that Bronson's application fell "squarely within that portion of MCL 500.3172(1) addressing claims for which 'no personal protection insurance applicable to the injury can be identified.'" Slip Op. at 8. Based on that, the Court of Appeals concluded that the circuit court's decision was "premature" because it was entered before any discovery had taken place as to whether or not Esquivel's vehicle truly was uninsured.

> It is not clear on this undeveloped record, however, that one of these scenarios exist. Esquivel's insurance status remains unknown. When he is deposed, the material fact missing from the no-fault equation will emerge. MACP has not yet carried its burden as the moving party to demonstrate with admissible

> evidence, rather than speculation, that Bronson was "obviously ineligible" to make a claim for benefits. [*Id.*]

The MACP applied for leave to appeal to this Court, which scheduled oral argument on the application, pursuant to MCR 7.305(H)(1).

LAW AND ARGUMENT

I. STANDARDS OF REVIEW.

Issues of statutory interpretation are reviewed *de novo*. *Echelon Homes, LLC v Carter Lumber Co*, 472 Mich 192, 196; 694 NW2d 544 (2005). However, because this appeal arises out of a grant of summary disposition under MCR 2.116(C)(10), the facts must be considered in a light most favorable to the party opposing the motion. *Maiden v Rozwood*, 461 Mich 109, 120; 597 NW2d 817 (1999).

II. THE ASSIGNED CLAIMS PROCEDURE.

The threshold question in any suit concerning a claim for no-fault benefits is whether the injury suffered is the type of injury the no-fault act is designed to compensate. *Wills v State Farm Ins Cos*, 178 Mich App 263, 265; 443 NW2d 396 (1989), aff'd 437 Mich 205 (1991). MCL 500.3105(1) provides: "Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter." Personal protection benefits include reasonably necessary medical care and treatment. MCL 500.3107(1)(a). A medical provider, like Bronson, is a claimant under the no-fault act and may directly pursue payment of its charges from insurers or, where applicable, the MACP. See *Wyoming Chiropractic Health Clinic, PC v. Auto-Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014), lv den 497 Mich 1029 (2015).

MCL 500.3172(1) sets forth the circumstances under which a claimant may seek benefits through the assigned claims plan. It provides in pertinent part:

> *A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor* vehicle as a motor vehicle in this state may obtain personal protection insurance benefits through the assigned claims plan if . . . *no personal protection insurance applicable to the injury can be identified* . . . . [Emphasis added.]

To apply for benefits under the assigned claims plan, the claimant must notify the MACP of the claim within one year of the accident. MCL 500.3174; Mich Admin Code, R 11.106(1). The administrative rules promulgated pursuant to MCL 500.3171 provide that a claim to the MACP "shall be on a form prescribed by the secretary of state" and that the claim "shall be completed in full, signed by the claimant, and submitted to the [MACP]." Mich Admin Code, R 11.106(2)-(3).

III. WHETHER A CLAIM IS "OBVIOUSLY INELIGIBLE."

This Court has ordered the parties to address "whether the Court of Appeals erred when it concluded that the [MACP] could not deny [Bronson's] application for assignment of its claims for benefits as 'an obviously ineligible claim,' MCL 500.3173a." MCL 500.3173a provides:

> (1) *The [MACP] shall make an initial determination of a claimant's eligibility for benefits under the assigned claims plan and shall deny an obviously ineligible claim.* The claimant shall be notified promptly in writing of the denial and the reasons for the denial.
>
> (2) A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the [MACP] for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits under the assigned claims plan. [Emphasis added.]

A. **The Legislature's plain language governs.**

When interpreting statutory language, this Court has explained:

> [O]ur goal is to give effect to the Legislature's intent, focusing first on the statute's plain language. In so doing, we examine the statute as a whole, reading individual words and phrases in the context of the entire legislative scheme. When a statute's language is unambiguous, the Legislature must have intended the meaning clearly expressed, and the statute must be enforced as written. No further judicial construction is required or permitted. [*Madugula v Taub*, 496 Mich 685, 696; 853 NW2d 75 (2014) (citations and quotation marks omitted).]

Where a statute does not define a term, it is appropriate to consult dictionary definitions to determine the plain and ordinary meaning of the term. *Allison v AEW Capital Mgmt, LLP*, 481 Mich 419, 427; 751 NW2d 8 (2008). Moreover, the doctrine of *noscitur a sociis* requires terms to be viewed in light of the words surrounding them. *Herald Co v City of Bay City*, 463 Mich 111, 129 n 10; 614 NW2d 873 (2000).

As the language of MCL 500.3173a(1) makes clear, "[t]here is limited authority to deny benefits as an initial matter by the [MACP] to make an initial determination of the claimant's eligibility for benefits and to deny 'obviously ineligible' claims." *KG v State Farm Mut Auto Ins Co*, 674 F Supp 2d 862, 870 n 3 (ED Mich, 2009). "Obviously ineligible" is not statutorily defined. Referring to their ordinary definitions, "obvious" means "[e]asily perceived or understood" and "ineligible" means "[d]isqualified by law, rule, or provision." *The American Heritage College Dictionary* (4th ed).

B. **"Obvious Ineligibility" must be determined by the application and accompanying documents.**

The only means by which the MACP may "easily perceive" whether a claim is "disqualified by law" is through its review of a claimant's application for benefits and its accompanying documents. As noted above, "[a] claim [to the MACP] shall be made on a form

prescribed by the secretary of state" and "shall be completed in full, signed by the claimant, and submitted to the [MACP]." Mich Admin Code, R 11.106(2)-(3). "A claim shall be accompanied by documentation of loss, if available, and the amount of loss sustained." Mich Admin Code, R 11.107(1). Accordingly, "obvious ineligibility" must be determined solely by reference to the application and its accompanying documents. Those documents are the basis of the claim. Any other interpretation of the phrase – the MACP to consider additional evidence – would frustrate the definition of "obvious." That is, the MACP cannot "easily perceive" any aspects of a claim that are not present in the application documents. Such additional perception would require additional investigation by the MACP, which is not permitted by the language of MCL 500.3173a(1).

This interpretation is further supported by the language of MCL 500.3173a(2), which penalizes providing false information to the MACP in support of a claim. This penalty and its placement in the same section with the "obvious ineligibility" provision, supports the central importance of the application materials to the MACP's role in assigning claims or denying claims. If the MACP were permitted (or required) to conduct its own investigation outside of the information provided by the claimant, the importance of this penalty would be diminished. Relatedly, once a claim has been assigned, "the servicing insurer [not the MACP or the claimant] *shall investigate* the claim expeditiously and make prompt payment for loss within the time prescribed by the act." Mich Admin Code, R 11.109(1) (emphasis added).

Moreover, because the language of MCL 500.3173a(1) is framed in the negative – "obviously ineligible" – eligibility of a claim should be presumed unless there is some easily perceivable reason for ineligibility. The Legislature could have just as easily framed the requirement in the positive – e.g., the MACP "shall grant an obviously eligible claim." It did

not. Accordingly, the MACP must determine "obvious ineligibility" to deny a claim; a claimant need not convince the MACP of "obvious eligibility."

The MACP ignores this distinction and cites a definition of "eligible" rather than the word actually employed by the Legislature – "ineligible." Supp. Br. at 5. This sleight of hand attempts to shift the MACP's statutory review standard from one that presumes eligibility absent "obviously ineligibility" to one that presumes ineligibility and demands proof of obvious eligibility – one where, as here, the MACP may rely on unknown information to deny assignment. That is precisely the opposite of what the statutory language dictates.

C. An "obviously ineligible" claim is one where, based on the application and accompanying documents, no-fault benefits are disqualified.

MCL 500.3173 provides that "[a] person who because of a limitation or exclusion in sections 3105 to 3116 is disqualified from receiving personal protection insurance benefits under a policy otherwise applying to his accidental bodily injury is also qualified from receiving benefits under the assigned claims plan." The primary section addressing the disqualification of benefits is MCL 500.3113.[2] It provides:

> A person is not entitled to be paid personal protection insurance benefits for accidental injury if at the time of the accident any of the following circumstances existed:
>
> (a) The person was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully, and the person knew or should have known that the motor vehicle or motorcycle was taken unlawfully.
>
> (b) The person was the owner or registrant of a motor vehicle or motorcycle involved in the accident with respect to which the security required by section 3101 or 3103 was not in effect.
>
> (c) The person was not a resident of this state, was an occupant of a motor vehicle or motorcycle not registered in this state, and the

[2] Other sections also provide bases for disqualification. For instance, MCL 500.3111 indicates that benefits are not payable for accidents that occur outside of the United States or Canada.

> motor vehicle or motorcycle was not insured by an insurer that has filed a certification in compliance with section 3163.
>
> (d) The person was operating a motor vehicle or motorcycle as to which he or she was named as an excluded operator as allowed under section 3009(2).

These provisions, filtered through the lens of a claimant's application and supporting documents, provide the bases for the MACP's denial of "obviously ineligible" claims. That is, if, based on a claimant's submission, (a) the injured person was operating an unlawfully taken motor vehicle, (b) operating their own motor vehicle without insurance, (c) was a non-resident occupant of a motor vehicle not registered or insured in Michigan, or (d) was operating a motor vehicle as to which he was a named excluded operator, the MACP would be required to deny the claim because it is obviously ineligible. Similarly, pursuant to MCL 500.3172(1), if insurance applicable to the injury can be identified, a person may not make a claim with the MACP. If, however, it is not "easily perceived" that those criteria are met, the MACP must assign the claim.

Of course, it may be the case that the assigned insurer, upon conducting its required investigation, Mich Admin Code R 11.109(1), ultimately finds facts that disqualify a claimant from receiving benefits pursuant to MCL 500.3113 or another section of the no-fault act or that there is applicable insurance. But pursuant MCL 500.3173a, further investigation is not the bailiwick of the MACP.

IV. BRONSON'S CLAIM WAS NOT "OBVIOUSLY INELIGIBLE."

Bronson followed the appropriate procedures. It submitted an application to the MACP on the form approved by the Secretary of State and included the Michigan State Police Original Incident Report, license plate and vehicle information from the Secretary of State, Bronson's medical bills, and the medical records relating to Esquivel's treatment. Thus, Bronson's application met the requirements of Mich Admin Code 11.106 and 11.107.

Bronson also met one of the four statutory triggers for seeking benefits from the assigned claims plan as set forth in MCL 500.3172(1). Bronson treated Esquivel for "accidental bodily injury arising out of the . . . use of a motor vehicle as a motor vehicle in this state," which is the threshold for no-fault coverage, and because "no personal protection insurance applicable to the injury [could] be identified," Bronson was empowered to obtain benefits through the MACP.

This is consistent with other decisions on the point. In *Spectrum Health v Grahl*, 270 Mich App 248, 252; 715 NW2d 357 (2006), the Court of Appeals stated:

> Titan was assigned Grahl's claim because, at the time of the assignment, both Grahl and the Assigned Claims Facility were unable to identify any other source of personal protection insurance applicable to cover Grahl's medical expenses. These are the first and second situations identified in [MCL 500.3172(1)]. Only when Titan began investigating the claim did it discover that Grahl had personal protection insurance through her estranged husband's policy with Farmers.

As in this case, Bronson was qualified to apply for benefits under MCL 500.3172(1) because it was unable to identify any other source of personal protection benefits *even though an applicable insurance policy may be identified in the future*.[3]

For the same reason, Bronson's claim was not "obviously ineligible" pursuant to MCL 500.3113(b) – the provision cited by the MACP as the basis for disqualification. Based on the facts known to Bronson at the time of its application (and the facts Bronson knows today), it was not clear that Esquivel was uninsured. Indeed, the MACP has conceded that it does not know whether or not Esquivel was insured. Therefore, in viewing Bronson's application and

[3] The MACP argues that if it is not allowed to look beyond "obviously ineligible" claims and consider information outside of the application documents, healthcare providers would simply stop inquiring into an injured party's insurance status "particularly if that party is likely uninsured." Supp. Br. at 10. This concern is unfounded. MCL 500.3172's language allowing MACP claims where no "insurance applicable to the injury *can be identified*," (emphasis added) indicates that there must be some good faith attempt by the claimant to obtain the information. Otherwise, the claimant could not assert that insurance information "could not" be identified. Further, and practically speaking, it is far simpler for a provider to obtain insurance information from a patient when it can than to undertake the time-consuming and often expensive process of applying for and obtaining benefits through the MACP.

supporting documents, the MACP could not determine that the claim was "obviously ineligible." If Bronson's application indicated that Esquivel was uninsured, then denial would have been appropriate under MCL 500.3173a because Esquivel was the registrant of the vehicle involved in the accident. It did not.

As explained above and, particularly, when the facts are viewed in the light most favorable to Bronson, its application for benefits to the MACP was not "obviously ineligible" under MCL 500.3173a. Accordingly, the Court of Appeals did not err. The MACP could not deny Bronson's application for assignment as "an obviously ineligible claim."

V. THE MACP'S URGED INTERPRETATION IS NOT SUPPORTED BY THE PLAIN LANGAUGE OF THE RELEVANT STATUTES.

A. That Esquivel's insurance status cannot be ascertained undermines the MACP's argument that a potential, higher-priority insurance renders Bronson's claim "obviously ineligible."

The MACP takes a far more expansive view of MCL 500.3173a and its power to deny claims as "obviously ineligible." It has argued that Bronson's claim was "obviously ineligible" because Esquivel was either (1) uninsured, in which case he would be excluded from receiving benefits as an uninsured registrant under MCL 500.3113(b), or (2) insured, in which case his own insurance carrier, not an MACP-assigned carrier, would be responsible for paying the bill. Therefore, the MACP argues, Bronson's claim is "obviously ineligible" under MCL 500.3173a.

For the reasons above, the MACP is incorrect. To point (1), it is not "easily perceived" that Esquivel was uninsured; therefore it is not "obvious" that Bronson's claim is ineligible under MCL 500.3113(b). Although Bronson's application does list Esquivel as the registrant of the vehicle, it states that Esquivel's insurance status is "unknown." To point (2), neither Bronson, the MACP, nor anyone else has been able to determine whether Esquivel is insured, let alone the identity of that potential insurer. Therefore, Bronson properly applied to the MACP because "no

personal protection insurance applicable to the injury [could] be identified." That is precisely what MCL 500.3172(1) instructs. That provision distinguishes between insurance that is "applicable" to a particular injury and insurance that may be applicable but cannot be "identified." In directing that a person may seek assigned claims benefits where no insurance "is applicable" or where no insurance "can be identified," MCL 500.3172(1) unambiguously assumes that in the latter case insurance may be available; it just cannot "be identified." The MACP's analysis ignores this crucial distinction.

The MACP's argument also runs afoul of *Spencer v Citizens Ins Co*, 239 Mich App 291; 608 NW2d 113 (2000). There, the victim of a hit-and-run accident was unable to identify the owner-driver of the vehicle that hit him. The Court of Appeals explained that the victim "qualified to receive benefits from the Assigned Claims Facility because no personal protection insurance applicable to plaintiff's injury could be ascertained." *Id.* at 302. Subsequently, the assigned insurer ceased paying benefits when it identified the insurer of the hit-and-run vehicle. In holding that the assigned insurer could not unilaterally terminate benefits under those facts, the Court of Appeals noted that "an assigned-claim insurer that subsequently ascertains a higher priority insurer cannot thereafter simply refuse to pay the assigned-claim insured party further benefits." *Id.* at 305. It continued that MCL 500.3175 provided that "the assigned-claim insurer must promptly reimburse the assigned-claim insured for any losses, while providing for the assigned-claim insurer the right and the duty to seek reimbursement from and enter settlements with any appropriate third parties, which category would include subsequently identified higher priority insurers." *Id.* at 306.

Under the reasoning of *Spencer* and the language of MCL 500.3172(1), the potential existence of no-fault coverage through another source does not disqualify a claimant from applying for and obtaining benefits from the MACP. The MACP's conclusion that Bronson was "obviously ineligible" for benefits because of the potential existence of higher priority coverage is therefore wrong.

B. **The MACP asks this Court to read language into the no-fault act.**

It is a cardinal principle of interpretation that "[n]othing will be read into a clear statute that is not within the manifest intention of the Legislature, as derived from the language of the statute itself . . . ." *King v Reed*, 278 Mich App 504, 513; 751 NW2d 525 (2008). The MACP's interpretation of MCL 500.3172(1) ignores this principle.

The MACP does not dispute that, under MCL 500.3172(1), there are circumstances where a claimant may recover benefits because no applicable insurance can be identified. What it argues, in effect, is that a vehicle *owner* injured in an accident while an occupant of his own motor vehicle can never seek benefits through the MACP on the grounds that no applicable insurance can be identified. However, no language in the no-fault act supports that conclusion. To the contrary, the MACP is asking that this Court to read into the no-fault act a limitation that has no textual basis – that hospitals, although proper claimants, may only receive benefits under MCL 500.3172(1) where "no applicable insurance can be identified *and the injured individual did not own the vehicle involved in the accident.*" Neither those words nor their substance is anywhere to be found in the no-fault act.

Moreover, it is important to keep in mind that Esquivel is not the claimant here; Bronson is. And, unlike the owners themselves, it is possible and entirely reasonable that a hospital may be unable to identify insurance in such a scenario. Hospitals are frequently unable to communicate with a patient to identify insurance before, during, or after treatment. The

MACP's analysis assumes that Bronson's claim is co-extensive with Esquivel's. To the contrary, MCL 500.3173a requires the MACP to make "an initial determination of the *claimant's eligibility* for benefits under the assigned claims plan." (Emphasis added.) Because Bronson is the claimant, its claim, not Esquivel's, must be evaluated for "obvious ineligibility." So the MACP's reimagining of MCL 500.3172(1) is inconsistent with MCL 500.3173a.

C. The MACP's position, not Bronson's, places an additional investigatory burden on the MACP.

In its application to this Court, the MACP correctly notes that under MCL 500.3173a, it is required to make an "initial determination" of eligibility of benefits and "deny an obviously ineligible claim." It then continues, "There is no statutory basis for the Court to conclude that the Legislature intended to make the MACP some sort of detective agency, charged with hunting for possible sources of insurance . . . ." App at 12. Bronson agrees.

It is the MACP's position, not Bronson's, however, that makes the MACP into "some sort of detective agency." As set forth above, it is Bronson's position that the MACP's assignment determinations under MCL 500.3173a must be made solely on the basis of the application and documents provided as required by Mich Admin Code, R 11.106(2)-(3). The MACP's sole, ministerial task in processing claims is simply to review them for "obvious ineligibility," reject those that are, and assign those that are not to a servicing insurer. It is then the servicing insurer's responsibility to investigate further. Mich Admin Code, R 11.109(1).

The MACP has asserted that it may conduct additional investigation. As explained above, that position is not supported by the language of the no-fault act.

CONCLUSION

For the reasons above, the Court of Appeals did not err when it concluded that the MACP could not deny Bronson's application for assignment of its claim for benefits as "an obviously ineligible claim" pursuant to MCL 500.3173a. When the statutory language is faithfully interpreted and when the facts are viewed in a light most favorable to Bronson, its claim was not "obviously ineligible," and the MACP, therefore, had no basis to deny it. Accordingly, this Court should deny the MACP's application for leave to appeal.

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